MaineCare Services
An Office of the
Department of Health and Human Services
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TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Final Rule: MaineCare Benefits Manual, Chapter II, Section 4, Ambulatory Surgical Centers

DATE: November 13, 2009

This letter gives notice of an adopted rule: MaineCare Benefits Manual, Chapter II Section 4, Ambulatory Surgical Center Services. These rules update the policy to reflect CMS changes in CMS-1392-FC. The Department incorporated several other structural and grammatical changes within this rulemaking.

The comment deadline for the proposed rule was July 24, 2009.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be viewed at and printed from the Office of MaineCare Services website or obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter II, Section 4, Ambulatory Surgical Center Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: These final rules update the definition of Ambulatory Surgical Center, per CMS Conditions for Care; update the conditions of care; clarify non-covered services; add documentation for assessments and informed consents; and make minor grammatical changes. This rulemaking has no adverse impact on small businesses employing fewer than twenty employees.

See http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: November 18, 2009

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SECTION 4 **AMBULATORY SURGICAL CENTER SERVICES** Established: 2/1/90
Last Updated: 11/20/09

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4.01 DEFINITIONS

Effective 11/18/2009

4.01-1 Ambulatory Surgical Center (ASC) means a freestanding facility that operates exclusively for the purpose of providing surgical services to persons not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission. The ASC must be certified by Medicare and comply with applicable licensure requirements, if any, in the State or Province in which it operates.

Ambulatory Surgical Centers reimbursed as part of an acute care hospital are excluded as providers under this Section of the MaineCare Benefits Manual.

4.01-2 Facility Services means items and services furnished by an ASC in connection with a covered surgical procedure.

4.02 MEMBER ELIGIBILITY

Individuals must meet the financial eligibility criteria set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

The provider is responsible for verifying a member's eligibility for MaineCare prior to providing services on each occasion that services are provided. See Chapter I of the MaineCare Benefits Manual for more information on verifying eligibility.

4.03 DURATION OF CARE

Each MaineCare member is eligible for as many covered services as are medically necessary. The Department reserves the right to request additional information to determine medical necessity.

4.04 COVERED SERVICES

Effective 11/18/2009

Covered services include all items and services furnished by an ASC in connection with a covered surgical procedure. Unless otherwise stated below, only surgical procedures currently on the Medicare-approved list of ASC covered procedures are allowed. See http://www.cms.hhs.gov/ASCPayment/ for the current listing. Coding for covered services is based on the latest version of the American Medical Association's standard Current Procedural Terminology (CPT) codes and can be accessed through the Department's website at: http://www.maine.gov/dhhs/oms/providerfiles/prov_portal_tools.html. The following items and services are covered services and are included in the all-inclusive rates for reimbursement in this Section of the MaineCare Benefits Manual:

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4.04 **COVERED SERVICES** (cont.)

A. The following are part of the all-inclusive rate:

1. Nursing, technical personnel and other related services;

These include all services in connection with covered procedures furnished by nurses, technical personnel and other support staff involved in patient care who are employees of the ASC.

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2. Use of surgical center facilities;

3. Drugs and biologicals for which separate payments are not allowed under the hospital outpatient prospective payment system (OPPS);

4. Diagnostic or therapeutic items and services;

These are items and services furnished by the ASC staff in connection with covered surgical procedures.

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Diagnostic tests, primarily urinalysis, blood hemoglobin, or hematocrit, performed just before surgery are included in the facility fee. The laboratory may perform diagnostic tests that may be required prior to surgery. Generally, these tests will have been performed prior to scheduling surgery under a CLIA certificate of waiver.

5. Administrative, record-keeping, and housekeeping items;

6. Blood, blood plasma, platelets:

Covered procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood and blood products
may be required. When there is a need for blood and blood products, they are considered facility services and no separate charge is permitted.

7. Materials for anesthesia;

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8. Medical and surgical supplies not on pass-through status;

9. Equipment;

10. Surgical dressings;

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4.04 **COVERED SERVICES** (cont.)

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11. Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status;

12. Implanted DME and related accessories and supplies not on pass-through status;

13. Splints and casts and related devices;

14. Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

15. Administrative, recordkeeping and housekeeping items and services;

16. Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

17. Supervision of the services of an anesthetist by the operating surgeon.

B. Prosthetic devices:

Prostheses such as joint and breast implants, artificial eyes and limbs, etc. may be billed in addition to the facility fee, using procedure codes listed in the most current version of the Healthcare Common Procedure Coding System (HCPCS), as maintained by the Center for Medicaid and Medicare Services (CMS). More information about HCPCS is available through CMS at: http://www.cms.hhs.gov/TransactionCodeSetsStands/, by calling 877-267-2323 (TTY 886-226-1819), or by contacting CMS at Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. Reimbursement will be made for the acquisition cost of the prosthetic device. Providers must maintain documentation of cost, including a copy of the original invoice, and make such documentation available to the Department upon request.

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C. Ancillary Services:

The following ancillary services may be billed separately from the facility fee, using procedure codes listed in the most current version of the Healthcare Common Procedure Coding System (HCPCS), as maintained by the Center for Medicaid and Medicare Services (CMS):

1. Brachytherapy sources;
2. Certain implantable items that have pass-through status under the OPPS;

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4.04 **COVERED SERVICES** (cont.)

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3. Certain items and services that CMS designates as contractor-priced, including but not limited to, the procurement of corneal tissue;

4. Certain drugs and biologicals for which separate payment is allowed under the OPPS.

More information about HCPCS is available through CMS at: http://www.cms.hhs.gov/TransactionCodeSetsStands/, by calling 877-267-2323 (TTY 886-226-1819), or by contacting CMS at Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

When an Ambulatory Surgical Center bills for services covered under this Section of the MaineCare Benefits Manual for a given operative procedure, the physician(s) involved in performing the operative procedure is to bill for his or her professional services only under Chapter II, Section 90, and not for related ancillary services such as anesthesia supplies, which are covered services under this Section.

4.05 **NON-COVERED SERVICES**

Facility services do not include physician services (Section 90); laboratory (Section 55), x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure) (Section 101); ambulance services (Section 5); leg, arm and back braces; or durable medical equipment for use in the member's home (Section 60).

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Other non-covered services include those services that cannot be safely performed in an outpatient setting or without support of a full array of hospital diagnostic and treatment services and equipment; and procedures that are not covered by MaineCare (e.g., cosmetic surgery).

Payment for Presbyopia-Correcting Intraocular Lens (P-C IOL) and Astigmatism-Correcting Intraocular Lens (A-C IOL) will be at the rate of a conventional Intraocular Lens (IOL).

Services are not separately billable unless specifically allowed under Medicare.

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4.06 POLICIES AND PROCEDURES

4.06-1 Professional Staff

A physician is a doctor of medicine or osteopathy who possesses a current license to practice medicine or osteopathy in the State or Province in which the services are provided.

4.06-2 Member Records

There shall be a specific record for each member that shall include, but not necessarily be limited to:

A. The member's name, address, and birth date;

B. The member's social and medical history, as appropriate;

C. Operative reports or procedure/treatment descriptions, as appropriate;

D. A description of any tests ordered and performed and their results;

E. A description of treatment or follow-up care and dates scheduled for revisits;

F. Any medications and/or supplies dispensed or prescribed;

G. Any recommendations for and referral to other sources of care;

H. The dates on which all services were provided;

I. Written progress notes, which shall identify the services provided, pathology specimens obtained, and where sent, as applicable;

J. Informed consents; and

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K. Assessment appropriate to the nature and scope of the procedure performed and the specific medical condition of the individual patient.

4.06-3 Program Integrity

See Chapter I of the MaineCare Benefits Manual, for Program Integrity procedures.

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4.07 REIMBURSEMENT

Reimbursement for covered services shall be made as described below. The reimbursement rate is an all-inclusive rate. Providers cannot bill for facility services separately.

4.07-1 Reimbursement shall be the lower of:

A. the lowest amount allowed by the Maine Medicare Part B carrier based on current Medicare rates; or

B. the provider's usual and customary facility charge.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment prior to billing the MaineCare Program.

4.07-2 Reimbursement for Multiple Procedures

When multiple procedures are performed in the same operative session, MaineCare will only pay for one procedure classified in the highest payment group. Providers are to bill only the surgical procedure code (with the designated modifier in the current HCPCS manual, currently "SG") in the highest payment group. Additional information about HCPCS is available through CMS at: http://www.cms.hhs.gov/TransactionCodeSetsStands/, by calling 877-267-2323 (TTY 886-226-1819), or by contacting CMS at Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

For purposes of this Section, an operative session is an ambulatory surgical visit in which one or more of the covered surgical procedures are performed.

For purposes of this Section, highest payment group is the highest rate from one of the nine ASC payment groupings established by Medicare at:

http://www.cms.hhs.gov/center/asc.asp.

4.08 BILLING INSTRUCTIONS

Effective 11/18/2009

Billing must be accomplished in accordance with the Department's billing instructions for the CMS 1500 that providers receive in their enrollment packages.